STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. BUILDING _____ B. WING _____	C 02/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility February 6, 2017 through February 8, 2017 and on February 13, 2017. The deficiencies cited in this report are based on resident and staff interviews, clinical record reviews, and review of other facility documentation. The survey sample size was (9) including two (2) closed records. The facility census the first day of the survey was one hundred and sixteen (116). Abbreviations/Definitions used in this report are as follows: NHA- Nursing Home Administrator; DON- Director of Nursing; NP- Nurse Practitioner; RN- Registered Nurse; UM- Unit Manager; SW- Social Worker; LPN- Licensed Practical Nurse; CNA- Certified Nursing Assistant; Activities of Daily Living-tasks needed for daily living such as dressing, hygiene, eating, toileting and bathing; Audiology- is a branch of science that studies hearing, balance, and related disorders; anticoagulant- blood thinner; Cognitively intact - Able to make own decisions; Continence - control of bladder and bowel function; Coumadin- a medication that thins the blood; erection- penis becomes firmer, engorged and enlarged; Incontinence - loss of control of bladder and/or bowel; Minimum Data Set (MDS)- An assessment tool used to assess nursing home residents;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/03/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 occasionally incontinent (urine)- less than 7 episodes of incontinence during a 7 day assessment period; overactive bladder- a chronic condition of the bladder that causes sudden urges to urinate; Perineal (peri-care)- washing of the genital and rectal areas of the body; X-times.	F 000		
F 166 SS=D	483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her	F 166		4/11/17

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F 166	Continued From page 2	F 166		

grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;

(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;

(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;

(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement

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F 166	Continued From page 3 as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interviews, closed clinical record reviews and a review of other facility documents, it was determined that the facility failed to adequately and promptly address resident/responsible party/family member's grievances (concerns) and/or follow the facility's Resident Concern/Compliment Form- Instructions For Use document. This deficient practice was evident for 2 (R1 & R2) of 9 sampled residents. Findings include: The facility's procedure/instructions document (undated) for Resident Concerns/Grievances included "all concerns and compliments by a resident, responsible party, and/or family member are documented by the staff member receiving the report using the Resident Concern/Compliment Form." The staff member receiving the concern takes immediate action in	F 166	1. Resident #1 and #2 no longer reside at the facility. 2. All residents that have concerns/complaints have the potential to be affected by the deficient practice. All concerns reported to date were completed and signed by the Administrator. 3. A root cause analysis was conducted regarding the timeframe of concerns being addressed/completed and the findings concluded that our concern form policy and follow up timeline was not efficient. The Administrator has now made it mandatory that all complaint/concern forms be brought the	

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F 166	Continued From page 4 an attempt to resolve the concern and documents the action(s) taken on the "Form." Completed forms are forwarded to the Nursing Home Administrator (NHA) designee who records the "Form" on the log and forwards to the NHA. The NHA reviews and forwards a copy of the "Form" to the pertinent Department Head(s) for follow-up. The follow-up and preventative measures are documented on the Form within five days. The NHA will review and sign completed "Forms" indicating resolution and proper distribution, then maintain the "Form" in a designated Concern/Compliment file. Review of facility documentation for R1 revealed the following: 1. Progress notes from 10/6/16- R1 was admitted to the facility with glasses, upper dentures and a hearing aid for the left ear. Face sheet indicated that the resident was 102 years old. The admission Minimum Data Set (MDS) dated 10/13/16 documented that the resident's cognitive skills were severely impaired and that R1 required extensive assistance with activities of daily living. Resident Concern/Compliment Form dated 10/28/16- a staff member documented that R1's family member found the hearing aid broken in a tissue box on the bedside table in R1's room. Resident "unaware that the hearing aid was broken." The facility's Department Head response dated 11/18/16 reflected that a phone call was made to the family member after R1 was discharged on 10/31/16. E1 (NHA) documented that he let the family member know that the	F 166	standup morning meeting to discuss a reasonable timeline for follow-up. Staff has been re-inserviced regarding our Concern Form Policy and reporting in a timely manner to the appropriate authority for follow up. Social Services will audit 5 concern forms weekly to inspect for resolution and completion. If needed, corrective action will take place immediately. Audits will be given to the Administrator for review. 4. Audits will be done weekly until 100% compliance for 3 consecutive weeks. Once 100% is achieved the matter will be considered resolved. Results of the audit will be reported to the QA Committee for a period of three (3) months. The QA Committee will determine what, if any additional interventions are required at the end of the three (3) month period.	

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F 166	Continued From page 5 facility does not replace broken items. "Staff was unaware of the hearing aid missing before discharge." The call to the family was made at least 20 days after the Concern Form was imitated. A statement attached to the 10/28/16 Concern Form dated 12/2/16 from E7 (SW) documented that he/she was called to R1's room. R1's family member informed E7 that R1's hearing aid was missing and he/she would like it found before they left. No dates or times regarding when the actual events occurred. The statement further revealed that a staff member brought E7 a container with a broken hearing aid in it, then a Concern Form was generated and E7 informed the family member that a full investigation would be done. The typed statement by E7 was dated 12/2/16 which was at least one month after the Concern Form was generated. There are discrepancies about who found the hearing aid and when it was found. E7 no longer works at the facility. During an interview with the surveyor on 2/8/17 at approximately 9:50 AM, E1 (NHA) stated he received a call from R1's family member regarding the hearing aid. E1 does not recall the specific date and has no documentation regarding that call. R1's family member felt that the facility was responsible for the hearing aid and wanted it replaced. The follow-up call to the family was as stated above under Department Head Response of 11/18/16. Review of the clinical record and facility documentation for R2 revealed the following: 2. Physician's orders started 12/20/16	F 166		

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F 166	Continued From page 6 documented that the resident was receiving a medication daily for overactive bladder. R2's admission MDS completed on 12/23/16 documented that the resident was cognitively intact. R2 was listed as always continent of bladder and bowel and required moderate assistance with toileting activities. Progress note 12/21/16 at 11:05 AM reflected that the resident was legally blind and able to make needs known. The point of care history report, used by the CNAs, for R2 documented that between 12/21/16 and 12/30/16 R2 had at least 8 episodes where the resident was listed as both continent and incontinent of urine at times. The data entries for that time period were from at least 3 different CNAs. MDS 14 day completed on 1/2/17 documented that R2 was occasionally incontinent of bladder. Complaint specifics 1/31/17 reflected that R2 was not assisted in a timely manner to the bathroom by one specific CNA which resulted in bladder incontinence. Staff were notified of the incidents prior to R2's discharge. During an interview with the surveyor on 2/6/17 at 2:07 PM, E3 (SW) stated that he/she does not remember receiving any written or verbal concerns regarding R2. E3 stated that the prior NHA took care of distributing the Concern Forms and for the last 3 months E3 has been keeping a log of the Concern Forms. There are no Concern Forms regarding R2.	F 166		

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F 166	Continued From page 7 E11 (CNA) stated during an interview with the surveyor on 2/8/17 at 7:05 AM that R2 told him/her about the incontinent episodes and not wanting E10 (CNA) to care for him/her anymore. E11 stated that R2's concerns were reported to E4 (RN-UM) and another nurse. E11 indicated that R2 did have bladder incontinence at times and E11 would assist R2 in changing his/her pull ups. During an interview with the surveyor on 2/8/17 at 7:50 AM, E4 (RN-UM) stated that he/she did receive a facility Concern Form regarding R2's issues with E10 (CNA). E4 went to see the resident who stated he/she had to wait for care and as a result wet his/her pull up. The resident indicated that E10 would have to pass trays and would not get to R2 quick enough. R2 told E4 that he/she did not want E10 providing care anymore. E4 stated that the assignments were immediately changed. E4 told E10 to switch with another CNA so he/she did not care for R2 anymore. During an interview with the surveyor on 2/8/17 at approximately 9:56 AM, E10 stated she was told by E4 to change assignments with another CNA so that he/she would not be caring for R2 anymore. No specific dates. E10 stated that R2 told her that he/she had the light on for 20 minutes and was upset. E10 had been passing out trays. R2 was wet and E10 assisted R2 after delivering the tray he/she was carrying. It was the next day that E4 told E10 of the assignment change. During a brief interview with the surveyor on 2/8/17 at approximately 10:30 AM, E2 (DON) reported that the facility had no Concern Form for	F 166		

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F 166	Continued From page 8 R2 and there was no facility documentation regarding the above issues with R2's care nor any documentation regarding any facility interventions. The findings were discussed with E1 (NHA) and E2 on 2/8/17 approximately 12:45 PM to 1:10 PM. E2 was informed during the exit conference on 2/13/17 at approximately 3:10 PM that there were no changes to the above findings.	F 166		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 279		4/11/17

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F 279	Continued From page 9 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on a staff interview, a closed clinical record review and a review of other facility documents, it was determined that the facility failed to develop a comprehensive plan of care to adequately address the hearing and	F 279	1. Resident #1 no longer resides at the facility 2. All residents with cognitive impairments have the potential to be	

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F 279	Continued From page 10 communication needs of R1 who had a hearing deficit and had a hearing aid for the left ear. This deficient practice was evident for 1(R1) of 9 sampled residents. Findings include: R1's clinical record revealed the following: Progress notes from 10/6/16- the resident was admitted to the facility with glasses, upper dentures and a hearing aid for the left ear. Face Sheet indicated that the resident was 102 years old. The admission Minimum Data Set (MDS) dated 10/13/16 documented that the resident's cognitive skills were severely impaired and that R1 required extensive assistance with activities of daily living. The care plan was initiated on 10/19/16 and documented the following: Problem area: Communication- Potential for alteration in communication related to hearing loss Goal: Resident will be able to effectively communicate basic needs and wants to staff x 90 days Approaches included the following- audiology consults as ordered/needed, face resident when speaking, get resident's attention before speaking, provide adaptive equipment for communication as indicated, provide reassurance and patience when communicating, speak clearly and in a non-high pitched tone, and use short direct phrases. The facility approaches did not include specifics	F 279	affected. An audit of care plans were completed for those residents who have been identified as having hearing or communication needs. 3. A root cause analysis was conducted and the findings were that we failed to put a system in place to effectively track the auditory devices along with care planning our interventions to make sure her devices were safe. As we identify those requiring hearing and communication needs we will individualize a system per resident that will allow staff to properly monitor auditory devices . RNACs and nursing staff were re-inserviced regarding communication and proper care planning for residents with hearing and communication needs. The Director of Nursing or designee will audit 5 charts weekly regarding care plans for residents to ensure interventions are in place for those residents who have communication and hear needs. 4. Audits will be done weekly until 100% compliance for 3 consecutive weeks. Once 100% is achieved the matter will be considered resolved. Results of the audit will be reported to the QA committee for a period of three (3) months. The QA Committee will determine what, if any additional interventions are required at the end of the three (3) month period.	

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regarding the use of R1's hearing aid or for ensuring proper use, removal and safeguarding of the hearing aid. The discipline listed as responsible for all of the approaches except audiology consults was the certified nursing assistants (CNA).

The point of care history document for R1 used by the CNAs from admission to discharge (10/31/16) showed no evidence that the CNAs caring for R1 had any care tasks listed or assigned that included assisting the resident with or putting the hearing aid in the ear for the resident daily nor removing and/or securing the hearing aid.

Resident Concern/Compliment Form dated 10/28/16- a staff member documented that R1's family member found the hearing aid broken in a tissue box on the bedside table in R1's room. Resident "unaware that the hearing aid was broken."

A facility Interagency Nursing Communication Record (Form B) dated 10/31/16 that is generated by staff for residents being discharged or transferred included but was not limited to the following:
-poor vision-glasses went with resident on discharge
-poor hearing- no areas checked off to indicate that the resident had a hearing aid and that the hearing aid went with the resident
- activities of daily living were documented as total assist in bathing, dressing, toileting and transfers

During a brief interview with the surveyor on 2/8/17 at approximately 10:00 AM, E2 (DON)

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F 279	Continued From page 12 stated that there were no other miscellaneous care tasks done for R1 during his/her stay by the CNAs that were documented in the point of care system. The surveyor briefly discussed concerns with R1's care plan regarding hearing loss and the lack of interventions/approaches specifically related to the use and care of R1's hearing aid. The findings were discussed with E1 (NHA) and E2 on 2/8/17 at approximately 12:45 PM to 1:10 PM. E1 was informed during the exit conference on 2/13/17 at approximately 3:10 PM that there were no changes to the above findings.	F 279		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, a review of clinical records and other facility documents, it was determined that the facility failed to provide appropriate and/or timely incontinent care for 2 (R2 & R3) of 9 sampled residents. Findings include: R3's clinical record revealed the following: 1. Admission Minimum Data Set (MDS) completed on 6/13/16 documented that R3 was moderately cognitively impaired. The Quarterly MDS completed on 9/13/16 and 12/14/16 did not have Section C- Cognition filled out. There was an entry in the Physician's	F 312	1 a) R3 is currently resides at our facility. R3 did not sustain major injury. b) All residents have the potential to be affected by this deficient practice. c) Nursing staff will be educated by staff D or designee on proper peri-care with return demonstration for competency. Nursing staff will complete sensitivity training to include male anatomy and proper care of. d) Random audits of peri-care will be completed by Staff D daily on 5 residents until 100% competency is achieved for 3 consecutive days. Then Staff D will complete random audits on 5 residents 3	4/11/17

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	085054	A. BUILDING _____ B. WING _____	C 02/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION PIKE CREEK	3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808

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F 312	Continued From page 13 Communication Book dated 1/11/17 (no time) from E5 (RN) which documented R3 had a big black spot on his penis area. "Please have it looked at." Progress Note dated 1/12/17 at 6:06 AM reflected that R3 had a large bruise, blood blister on penis. At that time R3 explained to the nurse that R3 had an erection and a CNA pushed the penis down and twisted it so that it would lay down. Event charted, wound care nurse notified and placed note in physician's book. Progress Notes 1/12/17 8:53 AM -R3 was seen by nursing supervisor who noted bruising. "Pt on an anticoagulant and resident denied any pain or difficulty voiding (urinating). Wound Healing Solutions document- date of service 1/12/17 at 9:05 AM - assessed by Nurse Practitioner (NP)- noted bruising and resident expressed pain when site was palpated. Plan included but was not limited to monitoring every shift and as needed, continue repositioning in accordance with facility policy, and contributing diagnosis includes Coumadin therapy. Send to emergency department for any of the following: increased bladder distention/urinary retention, increased penile swelling, increase bruising to area, blood in the urine and difficulty urinating. No specific treatment necessary at this time. R3 to be monitored carefully. Discussed plan with R3's family member. A facility reportable incident submitted to the Division of Long Term Care Resident's Protection (DLTCRP) on 1/12/17 at 5:15 PM documented the following:	F 312	times a week until 100% compliance is achieved with 3 consecutive evaluations. Then Staff D will complete random audits on 5 residents weekly times 3 weeks or until 100% compliance is achieved. Finally Staff D will complete random audits on 5 residents in one month if 100% is achieved the problem will have been considered resolved. 2a) R2 no longer resides at our facility b) R2 was not harmed by this deficient practice. All residents have potential to be affected by this deficient practice. c) Nursing staff will be educated on the policy of 2q hr rounds which include incontinence care or offer toilet residents. Nursing staff will be educated on timely call bell response and facility expectation in a timely manner. Nursing staff will attend sensitively training. d) Unit Managers will conduct random call bell audits to ensure timely response daily until 100% is achieved for 3 consecutive evaluations. Then Unit Mangers will complete random audits for call bells 3 times a week or until 100% compliance is achieved over 3 consecutive audits. Then Unit Mangers will complete random call bell audits once a week for 3 weeks until 100% compliance is achieved over 3 consecutive evaluations. Finally Unit Mangers will conduct random call bell audits in one month if 100% is achieved the problem will have been considered resolved.	

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F 312	Continued From page 14 A family member reported that R3 had bruising to the penis. According to the report a E12 (CNA) attempted to place an erect penis in a brief causing bruising. E12 was removed from the schedule. The facility's investigation done 1/12/17 documented that R3's statement was that a CNA came into the room to change brief and R3 had an erection "this happens sometimes." The CNA tried to put it down in the brief and it hurt. CNA asked if "I was okay" and I said yes." The CNA said he/she was sorry and asked if I needed an aspirin." E2 (DON) asked R3 at that time if it was abuse, and R3 stated no I don't believe it was malicious. E12's written statement dated 1/10/17 instead of 1/12/17 reflected much the same information as R3's verbal statement to E2. The actual incident occurred on the 11 PM to 7 AM shift on 1/10/17. The facility Concern/Compliment Form dated 1/12/17 contained the same information as the incident report submitted to DLTCRP. Progress note dated 1/12/17 entry 5:52 PM showed that R3 was assessed by the NP. No treatment necessary at this time. Facility In-service Record dated 1/25/17 documented that E12 received a review on proper male peri-care/incontinent care and given information on possible "bad outcomes from improper care." Surveyor interviewed E5 (RN) on 2/7/17 at 10:20 AM. E5 stated that on 1/11/17 (unclear of exact time in the morning) that E12 wanted him/her to look at R3. E5 checked the resident's penis and	F 312		

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F 312	Continued From page 15 found a black area and documented such in the Physician's Communication Book. Normally E5 would also document in the progress notes but could not recall if that was done. According to E5, the resident verbalized no concerns to him at that time, no pain and was voiding normally. E 5 indicated the resident was monitored. There was no documentation in the progress notes for 1/11/17 by E5 regarding his/her assessment. Progress Notes from 1/12/17 through 1/17/17- reflected that the resident was monitored and ice was applied on 1/12/17 to penis area for 20 minutes due to swelling. Bruising and swelling resolved with no further treatments by 1/17/17. During a brief interview with the surveyor on 2/6/17 at 1:55 PM, R3 had no concerns or issues related to care. During an interview with the surveyor on 2/7/17 at approximately 2:00 PM, E2 (DON) stated that the above investigation revealed that E12 did not provide proper care to R3 on 1/10/17. E12 was reeducated on the proper peri-care/incontinent care to provide to male residents. 2. Clinical record review for R2 revealed the following: Physician's orders started 12/20/16 documented that the resident was receiving a medication daily for overactive bladder. R2's admission MDS completed on 12/23/16 documented that the resident was cognitively intact. R2 was listed as always continent of bladder and bowel and required moderate assistance with toileting activities.	F 312		

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F 312	Continued From page 16 Progress note 12/21/16 at 11:05 AM reflected that the resident was legally blind and able to make needs known..... The point of care history report for R2 used by the CNAs documented that between 12/21/16 and 12/31/16 R2 had at least 8 episodes where the resident was listed as both continent and incontinent of urine at times. The data entries for that time period were from at least 3 different CNAs. MDS 14 day completed on 1/2/17 documented that R2 was occasionally incontinent of bladder. The point of care history report for R2 showed documentation between 1/2/17 and 1/14/17 that the resident was continent of urine on each entry. Complaint specifics 1/31/17 reflected that R2 had episodes of bladder incontinence and was not assisted timely with incontinent care by one specific CNA and the facility staff were notified of the incidents prior to R2's discharge. During an interview with the surveyor on 2/6/17 at 2:07 PM, E3 (SW) stated that he/she does not remember receiving any concerns regarding R2. E3 stated that the prior NHA took care of distributing the Concern Forms and for the last 3 months E3 has been keeping a log of the Concern Forms. There are no Concern Forms regarding R2. During a telephone interview with the surveyor on 2/7/17 at approximately 9:20 AM R2, who no longer resides at the facility, indicated that E10 (CNA) did not refuse to assist him/her but that	F 312		

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F 312	Continued From page 17	F 312		

when the resident put the callbell on he/she would sometimes have to wait for assistance for 30 minutes, especially when E10 was caring for him/her and as a result would wet the pull up. There were at least three occasions when this occurred. R2 did request a change in CNAs, which was done.

E11 (CNA) stated during an interview with the surveyor on 2/8/17 at 7:05 AM that R2 told him/her about the incontinent episodes and not wanting E10 to care for him/her anymore. E11 stated that he/she reported R2's concerns to E4 and another nurse.

During an interview with the surveyor on 2/8/17 at 7:50 AM, E4 (RN-UM) stated that he/she did receive a facility Concern Form regarding R2's concerns about E10. E4 went to see the resident who stated he/she had to wait for care and was wet in the pull up. The resident indicated that E10 would have to pass trays and would not get back to her quick enough. R2 stated he/she did not want E10 anymore. E4 stated that the assignments were changed verbally. E10 switched with another CNA so she did not care for the resident.

During an interview with the surveyor on 2/8/17 at approximately 9:56 AM, E10 stated she was told by E4 to change assignments with another CNA so that he/she would not be caring for R2 anymore. No specific dates as to when the event occurred. E10 stated that R2 told her that he/she had the light on for 20 minutes and was upset. E10 had been passing out trays. R2 was wet and E10 assisted R2 after delivering the tray he/she was carrying. It was the next day that E4 told E10 of the assignment change. E10 did acknowledge

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F 312	Continued From page 18 to the surveyor that CNAs have other task and there are times staff "can't be everywhere at the same time" and resident's may have to wait. E10 stated that sometimes he/she works the dining room at lunch and someone else would need to cover answering the callbells at those times. There was no specific system in place to ensure that resident's who needed assistance with toileting or other activities during meal deliveries and set-ups were accommodated in a timely manner. The findings were discussed with E1 (NHA) and E2 (DON) on 2/8/17 approximately 12:45 PM to 1:10 PM. E2 was informed during the exit conference on 2/13/17 at approximately 3:10 PM that there were no changes to the above findings.	F 312		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Pike Creek

DATE SURVEY COMPLETED: February 13, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by references and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from February 6, 2017 to February 8, 2017 and on February 13, 2017. The deficiencies cited in this report are based on resident and staff interviews, clinical record reviews, and reviews of other facility documentation. The survey sample size was (9) including (2) closed records. The facility census the first day of the survey was (116).		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code**	Cross reference EPOC submitted on 3/3/17 for F166, F279 and F312.	

Provider's Signature _____ Title Administrator Date 3/3/17

DELAWARE HEALTH AND SOCIAL SERVICES
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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed February 13, 2017: F0166, F0279, and F0312.		

Provider's Signature _____ Title Administrator Date 3/3/17